Continuity of Care Advisory Panel

September 4, 2013

Economic Workgroup Presentation

Spring Grove Hospital Center (Dix Building)

I. The meeting commenced at 10:00 am in the basement of the Dix building after participants signed in on the designated workgroup sheet. Dr. Gayle Jordan-Randolph began with opening remarks welcoming participants to comment on the findings and recommendations of the Economic Workgroup that would be presented today. Dr. Jordan-Randolph also thanked Senator Delores Kelley for attending the Advisory Panel's meeting. Individuals who called in to the meeting were instructed to identify themselves and email Erin McMullen their contact information. Call in attendees included: Beth Wiseman, Steve Daviss, Charles Gross, Carolyn Knight, Janet Edelman, Gregory Burkhart, Yvonne Perrett, Derrick Richardson, Silvana Dill, and Cat Pangilinan. Dr. Jordan-Randolph indicated that Dr. Steve Goldberg, chair of the Economic Workgroup, would present preliminary findings and recommendations made by the Economic Workgroup. After his presentation, workgroup members will be allowed to comment on the presentation, followed by a period for public comment.

II. Economic Workgroup Presentation

a. Dr. Goldberg informed the Advisory Panel that the workgroup was waiting to receive the data it requested from ValueOptions and the Health Services and Cost Review Commission before it finalized its observations and recommendations. The Economic Workgroup was diverse in its membership with differing opinions. For ease of discussion and to organize our observations and recommendations, the workgroup broke down our discussions of economic barriers to continuity of care into subgroups from the perspective of consumers, providers, system-wide barriers, and barriers as they relate to locus of care.

b. Economic Barriers for Consumers

i. **Insurance Status.** Dr. Goldberg discussed the concept of churning and national estimates of transition rates between Medicaid and qualified health plans offered through exchanges. Approximately 35 percent of adults with a household income below 200 percent of the federal poverty level are estimated to have at least one income-related transition within six months.

1. Continuity of Care provisions from the Maryland Health Progress Act of 2013 (Chapter 159) were discussed. The policies in Chapter 159 generally require a receiving carrier or managed care organization (MCO) to accept preauthorization from a relinquishing carrier, MCO, or third-party administrator for treatment of covered services for a specified period of time. Chapter 159 also generally requires carriers and MCOs to allow nonparticipating providers to continue health care services for specified time periods. The receiving carrier or MCO must pay the nonparticipating provider the rate and use the method of

payment the carrier or MCO would normally pay and use for similar participating providers.

2. The workgroup indicated that the effectiveness of these continuity of care provisions should be evaluated by the Department of Health and Mental Hygiene (DHMH), the Maryland Health Benefit Exchange, and the Maryland Insurance Administration (MIA) post 2015 and propose necessary modifications.

ii. **Access Point to Mental Health Services.** Economic barriers to access mental health services have a negative impact on continuity of care. Economic barriers may include transportation, an inability to take off work, or lack of childcare. Economic barriers to appropriate outpatient mental health services increase the need for crisis management, and thus higher levels of emergency room and inpatient hospital utilization for individuals with behavioral health conditions.

1. One way to reduce emergency room visits is to ensure that individuals have access to appropriate care in the community when they need it. Currently, DHMH has data on Maryland Health Professional Shortage Area designations for mental health providers.
2. Despite the availability of information regarding mental health professional shortage areas, additional information regarding the availability of community mental health providers in all areas of the State need to be assessed, including the number of providers who see children and older adults. Other areas that need to be addressed are current wait times to see mental health providers and what type of insurance or medical assistance providers accept. Using this information the state could better define shortage areas.
3. As a part of the Economic Workgroup's final report, additional data surrounding emergency room utilization by individuals with serious mental illness will be analyzed. Steps to improve provider availability can be taken that are geographically appropriate and discipline specific once additional data is available. Improving health literacy would enhance utilization of current state programs.

iii. **Health Literacy.** The National Assessment of Adult Literacy measures the health literacy of adults living in the United States. Health literacy was reported using four performance levels: (1) below basic, (2) basic, (3) intermediate, and (4) proficient. Ultimately, only 12 percent of the U.S. population was reported as having a proficient health literacy level.

1. Both consumers and providers should be the target audience of health education and health literacy campaigns. Maryland should prioritize health literacy as a component of all health care initiatives it is undertaking, including the Health Enterprise Zones, the State Innovation Model Grant Project, and the Patient Centered Medical Home Model. Moreover, connector entities funded through the Maryland Health Benefit Exchange can assist with improving health literacy. This was one area where the workgroup was in strong agreement.

c. Economic Barriers for Providers
    i. **Exclusion from the Health Information Exchange (HIE).** The HIE does not currently receive information from substance abuse or mental health providers. In order to ensure continuity of care for individuals with serious mental illness, the workgroup recommends that money be allocated to modify the HIE so that it can include substance abuse and mental health provider information. Failing to include health information from substance abuse or mental health providers in the HIE perpetuates discontinuity of care and results in higher health care costs for those with serious mental illness.
    ii. **Electronic Health Records (EHR).** If there was an EHR incentive program for behavioral health providers, EHR utilization would increase. When the HIE is able to include behavioral health information, the state should review active state and federal EHR incentive programs to ensure that the economic incentives are in place to encourage EHR utilization among behavioral health providers, thus improving continuity of care.
    iii. **Telemedicine.** Telemedicine was identified as a barrier for consumers, providers, and the entire mental health system. It will be discussed more as a locus of care issue.
d. System-wide Economic Barriers
    i. **Regulation of Provider Networks.** The workgroup concluded that current regulations are not sufficient to ensure provider networks are adequate. MIA should undertake proactive periodic reviews of insurers' proposed networks. MIA must enhance its visibility to make it easier for individuals to lodge complaints, including requiring insurers to list the MIA number on the provider directories. Additionally, the consequences to continuity of care when networks are inadequate or difficult to navigate are so significant that current regulations regarding the annual requirement to evaluate provider networks is insufficient to meet consumer needs and the frequency of such provider network reviews should be increased. To ensure compliance with this regulation, financial consequences should also be implemented when insurers fail to maintain updated provider networks.
e. Locus of Care
    i. **Hospital-based Psychiatry Services.** Hospital-based care is considered costly and hospitals are predominately viewed as providers of inpatient services. However, in most hospitals, the balance has shifted to ambulatory services, especially in psychiatry where many hospitals provide a full continuum of care from the most to least intensive psychiatric services.
        1. When consumers need to receive care along the full continuum of psychiatric services offered by a hospital, forcing them to go to non-hospital community-based provider for certain levels of care can have an economic impact to the consumer (i.e. transportation, missed work, child care, etc.) and fragments their treatment, thus it has the potential to produce poor clinical outcomes due to discontinuity and interruptions in treatment.

2. Final recommendations in this area will be formulated once the workgroup has received relevant data from the Health Services and Cost Review Commission.

ii. **Inpatient Bed Space**. Statewide inpatient bed space is impacted by bottlenecks created in the public mental health system as a result of consumers with forensic involvement. More specifically, the workgroup aimed to determine what the impact of locus of care for competency restoration is: (1) on the State Psychiatric Hospitals; (2) inpatient bed space throughout the entire mental health system; and (3) emergency room utilization. Recommendations in this area will be developed once the workgroup has received relevant data.

iii. **Community and Jail-based Competency Restoration.** The workgroup developed a consensus that the hospital is the most expensive setting to provide competency restoration. Jail-based competency restoration is approximately 60% cheaper than hospital-based restoration. Moreover, community-based competency restoration is 80% cheaper than hospital-based restoration. The Advisory Panel should assess jail and community based competency restoration as viable options for the State. However, legal and clinical concerns should be taken into account.

iv. **Outpatient Civil Commitment.** The workgroup reviewed literature surrounding outpatient civil commitment, primarily in New York. Among other things, the question of the costs of implementing an outpatient civil commitment program was discussed. The workgroup remains uncertain that outpatient civil commitment successfully engages individuals with serious mental illness in treatment and eliminates the "revolving door" to the emergency room. Without additional data, the workgroup cannot make a sound recommendation. If an outpatient civil commitment law were to be implemented, the workgroup strongly recommends that the program include an annual mandated appropriation level in the state budget that is adjusted annually for inflation. A program evaluation and Sunset provision should also be included in any legislation regarding outpatient civil commitment.

III. Workgroup Member Comments

a. Suzanne Harrison – The workgroup looked at economic disadvantages to continuity and ways to enhance the system so that the highest cost services were minimized as much as possible. Comments of the workgroup tried to focus on the whole person as those with serious mental illness are likely to be dually diagnosed and/or have somatic health issues. In regards to locus of care, hospitals have the potential to be a one stop shop to enhance continuity and coordination of care. HSCRC rates can be burdensome.

b. Kait Roe – Medication is vital to treatment and the issue of copays must be addressed. Forcing an individual to wait for their medication can affect health care. There should be an incentive for consumers to receive 90 day prescriptions via mail. There are costs savings that can be achieved here. Provider networks are inadequate. They do not have information related to mental health providers or their available services. We should require carriers to post this information on their web-based directories.

c. Dan Martin – The workgroup's presentation accurately reflects the conversations from workgroup meetings.
d. Steve Daviss – For locus of care issues, economic barriers for patients with full-time jobs, and taking off work for appointments can be a challenge. Telemedicine is one way to address this. Medical costs not for just patients in the mental health system, but all Marylanders, indicate that people with co-occurring somatic, substance abuse, and mental health conditions are extremely costly to treat. These individuals are at 8 to 15 times at greater risk for hospitalizations. Network adequacy is also a problem. There are not enough providers, particularly in commercial markets, but Medicaid, too. We should increase the transparency in provider networks so you can see when individuals are not accepting new patients. This could be incorporated as the facebook "thumbs up" idea for provider networks. Networks should also include wait times and allow providers to update their own directory.
e. Elaine Carroll – Transitional age you need to be addressed as young people are falling through the cracks. There is a more streamlined approach to insure this does occur. Health literacy programs need to include whole families and account for cultural differences. Peer support programs in the state are economically efficient and truly help divert individuals from the ER.

IV. Public Comment
a. Susan Kneller - If we had an endless supply of money, no rules, and no regulations, how can we address those with serious mental illness who do not seek treatment?
    i. Dan Martin – Engagement.
    ii. Sarah Rhine – The economic workgroup was tasked to look at economic barriers to continuity of care, this is not an appropriate question to discuss for this workgroup.
b. Tim Santoni – Asked whether the group addressed Medicare copays for individuals with serious mental illness. Even after ACA implementation, there will still be high copays (20-24%) for those who are dually eligible for Medicaid and Medicare. The workgroup should explore this issue.
    i. Dr. Goldberg – We tried to focus on high-end utilizers regardless of insurance status.
c. Lois Fisher (Office of the Public Defender) – Keeping people who are mentally ill and incompetent to stand trial in a correctional facility creates constitutional problems. Detention centers serve a purpose to make sure people show up to trial. Keeping someone in jail in hopes that they will become competent violates the 8th Amendment. The health care workforce shortage can be addressed through Loan Assistance Repayment Programs (LARP).
    i. Dr. Goldberg – From an economic standpoint, jail-based competency restoration is less expensive. Whether we should implement such a program is not the group's recommendation. Rather, the workgroup recognized that there are other ways competency restoration has been addressed in other states. They have addressed constitutional barriers.

ii. Lois Fisher – Other states have shorter time limits to achieve competency. Maryland limits are most likely not going to change.

d. Ed Kelly – The seriously mentally ill population is a significant cost to the State and this population has grown dramatically. The public mental health system is trying to keep up with this growth. The economic impact of this group on the mental health system, the courts, and law enforcement is devastating to the State. We need to find ways to insure early treatment to reduce these costs.

e. Erik Roskes – Did the workgroup look at Jackson limits? These limits address the amount of time that someone can be committed as incompetent. Maryland's are much longer than most states. We cannot retain individuals indefinitely because commitment has to be for competency restoration. In New York, if you are declared incompetent to stand trial for a misdemeanor offense, charges are dismissed. Two-thirds of individuals at Springfield that are court-involved are there due to misdemeanor charges. Did the workgroup review the Kelly decision regarding forced medication.

i. Dr. Goldberg – The workgroup is waiting for additional data and limits need to be taken into account.

f. Laura Cain - Maryland has chosen not to look at involuntary medication for competency restoration. Statute looks at dangerousness not restoration to competency. For jail-based competency restoration, she agreed with Lois Fisher, there are constitutional issues. Certain courts use a trial to get people into hospitals to get an appropriate discharge plan. This is very costly at Spring Grove, if an individual didn't have a mental illness, their charges would be dismissed. This is an issue all groups should address.

g. Senator Kelly – When she was chair of the Women's Caucus, they visited the mentally ill in a correctional facility. She does not view jail as a clinical setting and does not think that it is productive to spend time exploring jail-based competency restoration programs.

h. Denise Szulbach – We didn't hear much about transitional age youth. Three-quarters of young adults are diagnosed by age 24. Costs grow the longer we wait to get someone into treatment.

i. Catherine Bright (AA County Core Service Agency) – Diversion programs are still being funded by counties despite state funding cuts. Some counties have a 311 system that assist individuals with many things including scheduling appointments.

j. Anita Everett – Were service financing structures discussed? Accountable care organizations, can achieve cost savings. We could model programs after the assertive community treatment program. While it is hard to get into this program, there are also legal issues that have to be sorted out. In regards to the workforce, this is an opportunity to discuss graduate level loan repayment. Currently LARP goes to medically underserved areas. We should also increase peer support. They are an important part of the workforce.

k. Edgar Wiggins – Crisis intervention programs divert individuals from hospitals. Substantial savings are achieved through crisis intervention services. These programs treat individuals in their homes and the community.

l. Evelyn Burton – The workgroup should consider the article *Cost of Assisted Outpatient Treatment: Can it Save States Money?* Savings from assisted outpatient programs are evident.
m. Lori Doyle – She agreed with Dr. Everett. The workforce shortage also needs to look at the unlicensed individuals who are paid low wages. We need to realign the financial and regulatory environment to support creative provisions of services. Capitation programs result in a difference in how you do things when there is financial risk associated with outcomes. Fee for service doesn't achieve this.
n. Holly Ireland – Consumer issues around transportation, need for childcare, taking off work, etc. are real. There are tremendous transportation problems on the shore. People would have to take a whole day off work to use public transportation for a 45 minute appointment. Are we looking at other infrastructure systems? Formularies to fund services don't account for the rural transportation factor. Diversity of urban/suburban/rural areas need to be addressed. Rural jurisdictions are only ones that benefit from telemedicine. Challenges remain in regulations to ensure that the standard of care for telemedicine is compliant with health tech act and HIPPA. Protections for consumer need to be resolved.
o. Catherine Bright – Medicaid is suspended when an individual is incarcerated. When they are released they have to reapply and it takes time for individuals to be insured.
p. Sarah Rhine – There is too much focus on regional beds, and stays in regional hospitals being too long. A lot of these people may be dually diagnosed with an intellectual disability and transferring these individuals to psychiatric hospitals won't give them the care they need.
q. Lois Fisher – Is the department considering merging the Developmental Disabilities Administration (DDA) with the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA)?
    i. Dr. Jordan-Randolph – The department was able to consolidate MHA and ADAA with legislative support. Habilitative services are an entitlement under DDA, and different criteria is used in the DDA system than in MHA and ADAA. DDA has a new acting director (Patrick Dooley) and the department is consolidating and reorganizing DDA. There is a new clinical director at DDA and the department is recalibrating how clinical issues are addressed at the regional level.
    ii. Dr. Boronow – Serving transitional age youth in the DDA system is a problem.
r. Kait Roe – It sounds like the state's systems are soiled.
    i. Dr. Jordan-Randolph – The state is in the process of behavioral health integration. As a part of this process regulations will be updated to help reduce these silos.
s. Evelyn Burton – Housing is a huge economic barrier to care. Have we looked at housing programs that the state supports.
    i. Dr. Goldberg – The workgroup didn't have opportunity to look at this due to time constraints.

ii. Susan Nealor –Mental illnesses are not treated equally. There are special care units for Alzheimer's units. If a person has schizophrenia, there is nowhere to go. We need housing for these types of individuals.

t. Dr. Boronow – Wanted to pose a question to the whole group. Does the managed care fee for service model work? Are block grants and more effective? Do the 15 years of managed care privatization work?

V. Closing Remarks

a. Dr. Jordan-Randolph thanked everyone for their participation and noted that a presentation will be scheduled to address outpatient civil commitment. The date of the presentation has not yet been determined

Meeting minutes prepared by Erin McMullen and Stacy Reid Swain, Esq.